

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESAH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 445392	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	DATE SURVEY COMPLETE: 11/20/2013
NAME OF PROVIDER OR SUPPLIER ADAMSPLACE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1927 MEMORIAL BOULEVARD MURFREESBORO, TN		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 356	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post accurate nurse staffing information for one of one nursing units.</p> <p>The findings included:</p> <p>Observation on November 18, 2013, at 9:59 p.m., revealed the staffing information posted did not accurately reflect the nursing staff on duty for November 18, 2013. The observation revealed there was not a Registered Nurse scheduled for any shift on November 18, 2013.</p> <p>Interview with the Assistant Director of Nursing (ADON) on November 19, 2013, at 1:19 p.m., at the nurse's station confirmed there was a Registered Nurse on duty the date of November 18, 2013, and the staff information posted was incorrect.</p>		

Any deficiency statement ending with an asterisk(*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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PRINTED: 01/28/2014
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OMB NO. 0938-0391

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F 000	INITIAL COMMENTS During the Annual Recertification survey conducted from November 18 through November 20, 2013, at Adamsplace, LLC., no deficiencies were cited in relation to complaint #32487 under 42 CFR PART 483.13, Requirements for Long Term Care.	F 000	The Plan of Correction is submitted as required under State and Federal Law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct.		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	F278 It is the policy and procedure of AdamsPlace HCC to complete a resident assessment that accurately reflects the resident's status. The MDS for resident #91 was unlocked, corrected and retransmitted to the state to reflect the accurate wound care status for the MDS dated 10/14/13. A clinical record review was completed on 12/10/13 by Director of Nursing to ensure that accurate wound care status for any patient with a wound was coded. DON in-serviced the QA nurse regarding accurate wound coding for any wounds identified on 12/09/13. DON and/or designee will complete a QA monitor monthly for 3 months and as needed to ensure ongoing compliance.	12/13/13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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OMB NO. 0938-0301

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F 278	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to accurately identify pressure ulcers on the Admission Minimum Data Set (MDS) dated October 14, 2013, for one resident (#91) of four residents reviewed for pressure ulcers.</p> <p>The findings included:</p> <p>Resident #91 was admitted to the facility on October 7, 2013, with diagnoses including Dementia, Seizures, and Pressure Ulcer of Heel.</p> <p>Medical record review of the Physician Orders dated October 07, 2013, revealed "pressure area identified upon admission" and orders for daily pressure ulcer treatment.</p> <p>Medical record review of the Weekly Wound Assessment Progress Note dated October 7, 2013, revealed "...Lt (left) heel /c (with) 2 (two) sDTIs (Suspected Deep Tissue Injury). Areas are purple, intact blister. Tissue is mushy...Rt (right) heel /c DTI. Area is purple /c mushy, intact blister present...Stage One pressure ulcers present to bilateral ischial tuberosities..."</p> <p>Medical record review of the MDS dated October 14, 2013, revealed no pressure ulcers were documented.</p> <p>Interview with the MDS Coordinator, on November 20, 2013, at 1:35 p.m., in the MDS office, confirmed there no pressure ulcers were documented on the Admission MDS, and the MDS was inaccurate.</p>	F 278			

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F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of the meal intake record, facility policy review, and interview, the facility failed to weigh a resident weekly after admission and failed to reweigh the resident after a weight discrepancy for one resident (#224), of twenty residents reviewed.</p> <p>The findings included:</p> <p>Resident #224 was admitted to the facility on October 31, 2013, with diagnoses including Aftercare Fracture/Public Ramus, History of Fall, Difficulty Walking, Atrial Fibrillation, Long Term Use Anticoagulant Therapy, Coronary Atherosclerosis, Sinoatrial Node Dysfunction, Cardiac Pacemaker, History Pulmonary Embolism, Hypertension, Peripheral Vascular Disease, Anemia, Hiatal Hernia, Gastroesophageal Reflux, and Macular Degeneration.</p> <p>Observation on November 19, 2013, at 12:30 p.m., and on November 20, 2013, at 8:30 a.m., revealed the resident in the resident's room self feeding the meals. Further observation revealed the resident consumed 75-100 percent of both meals observed.</p> <p>Medical record review of the Admission Minimum</p>	F 281	<p>F281</p> <p>It is the policy and procedure of AdamsPlace HCC to provide services that meet professional standards of quality. Resident #224 was reweighed on 11/20/13 with findings documented properly and reported to NP. All other patients weights were reviewed by Director of Nursing and Assistant Director of Nursing to ensure proper weight procedures were followed. All nursing staff will be in-serviced regarding weighing policy and procedure by Director of Nursing and or designee. DON and/or designee will complete QA monitor weekly for 3 weeks and as needed to ensure ongoing compliance.</p>	12/17/13	

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F 281	<p>Continued From page 3</p> <p>Data Set dated November 7, 2013, revealed the resident was moderately cognitively impaired and was independent with eating after set-up.</p> <p>Medical record review of the hospital data dated October 28, 2013, revealed the resident's initial weight was "64.5455 kilograms" (142 pounds).</p> <p>Medical record review of the Admission Nursing Assessment dated October 31, 2013, revealed the resident's weight was 161 pounds, had bilateral lower extremity edema, and had complaints of difficulty/pain with swallowing.</p> <p>Medical record review of the Nursing Progress Notes dated November 2-10, 2013, revealed the resident had bilateral lower extremity edema, TED hose (compression device) worn, legs elevated on pillow, and/or bilateral heels off loaded.</p> <p>Medical record review of the Weight Record revealed the admission weight was 161 pounds and the usual body weight was 142 pounds at home. Further review of the Weight Record dated November 13, 2013, revealed the resident's weight was 140 pounds, a decrease of 21 pounds in fourteen days.</p> <p>Review of the meal intake record revealed the resident consumed 75-100 percent of every meal after November 11, 2013.</p> <p>Medical record review revealed the resident was ordered a speech therapy evaluation and treatment at admission and therapy remained ongoing with improvement.</p> <p>Review of an undated facility policy entitled</p>	F 281			

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F 281	<p>Continued From page 4</p> <p>"Weighing Procedure" revealed "...The nursing assistant is responsible for weighing all residents...If a resident has a difference in weight of plus or minus five pounds at the time of weighing, the nursing assistant will reweigh the resident within twenty-four hours. The nursing assistant is to notify the charge nurse immediately. The charge nurse will assess the resident and initiate interventions as needed which may include notifying the physician or nurse practitioners the dietitian, family and care plan team. Weights and reweights are to be documented in the patients medical record..."</p> <p>Review of a facility policy entitled "Documentation Guidelines" revealed "...Weights: should be recorded on the appropriate form. 1) Time frames a) Weekly for 4 weeks following admission. b) At least monthly, unless ordered on a more frequent schedule by the physician, nurse, or dietitian...3) Any unusual variation in weights should be verified by re-weighing the patient. a) Document the results. b) If unusual variation still exists, report to licensed nurse, who reports to physician..."</p> <p>Interview on November 20, 2013, at 10:14 a.m., with the resident in the resident's room, revealed the resident was aware of the admission weight of 161 pounds and had told the staff (resident) had not weighed that much in many years and "...didn't believe it (the admission weight) was right..." Further interview revealed the resident clothes fit the same from admission to the current date.</p> <p>Interview on November 20, 2013, at 10:20 a.m., with Certified Nurse Aide (CNA) #1, in the resident's room, confirmed CNA #1 admitted the</p>	F 281			

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F 281	Continued From page 5 resident and noticed no difference in the residents weight from admission to the current time. Further interview revealed the CNA noticed no difference in the way the clothes fit the resident. Interview on November 20, 2013, at 10:39 a.m., in the Registered Dietitian (RD) office, with the Director of Nursing and RD, confirmed the facility failed to weigh the resident weekly after admission and failed to reweigh the resident after the weight discrepancy per facility policy.	F 281			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to store food under sanitary conditions and failed to maintain a clean and sanitary kitchen. The findings included: Observation on November 18, 2013, at 7: 20 p.m., in the kitchen revealed on the shelving unit next to the steam table: 1. An unsealed open package of Quick Oats.	F 371	F371 It is the policy and procedure of AdamsPlace HCC to procure food from sources approved or considered satisfactory by Federal, State or local authorities and store, prepare, distribute and serve food under sanitary conditions. Pork was properly covered and stored on 11/18/13. Sealed plastic containers provided for unopened cereals/spices to be stored on 11/19/13. Chef and cook completed thorough cleaning of fryer, oven doors and steam table on 11/19/13. Dietary staff in-serviced completed by Certified Dietary Manager on 12/18/13 regarding proper storage of food and proper cleaning techniques of equipment to include fryer, steam table and oven. CDM and/or designee will complete a QA monitor weekly for 3 weeks and as needed to ensure ongoing compliance.	12/18/13	

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F 371	<p>Continued From page 6</p> <ol style="list-style-type: none"> 2. Two unsealed and opened packages of Crème of Wheat. 3. An unsealed and opened package of Grits. 4. An unsealed and opened box of baking soda. 5. An unsealed and opened package of Creole Seasoning. 6. An unsealed and opened package of White Rice. 7. An unsealed and opened package of Brown Rice. 8. One bottle of Heinz 57 Sauce with the cap opened. <p>Further observation in the kitchen on August 18, 2013, at 7:30 p.m., revealed:</p> <ol style="list-style-type: none"> 1. The third bin of the steam table had food debris floating in the water. 2. In the walk-in refrigerator a pan of partially cooked pork tips was not fully covered or sealed with plastic wrap and the meat was exposed. Stored on top of and touching the partially cooked pork tips was a fully cooked pork wrapped in foil. 3. Two convection ovens with dark brown flaky debris on the interior. 4. A deep fryer filled with black oil uncovered with debris floating on the top of the oil. <p>Interview with dietary personnel #1 on November 18, 2013, at 7:40 p.m., in the dietary office confirmed the facility failed to store food properly and maintain a clean and sanitary kitchen.</p>	F 371			
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a</p>	F 441			

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F 441	<p>Continued From page 7</p> <p>safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain clean oxygen concentrator</p>	F 441	<p>F441</p> <p>It is the policy and procedure of AdamsPlace HCC to ensure an infection control program is in place to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. All oxygen concentrator filters were cleaned on 11/20/13. Respiratory therapist was in-serviced by his supervisor on 12/10/13 regarding proper procedures for cleaning oxygen concentrator filters upon each visit. Director of Nursing and/or designee will complete a QA monitor monthly for 3 months and as needed to ensure ongoing compliance.</p>	12/13/13	

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F 441	Continued From page 8 filters for one resident (#217) of twenty residents reviewed. The findings included: Resident #217 was admitted to the facility on November 4, 2013, with diagnoses including Diastolic Heart Failure, Hypertension, and Functional Decline. Medical record review of the physician orders dated November 8, 2013, revealed "...oxygen per nasal cannula at 2-3 liters to keep saturation greater than 88 percent.." Observation on November 19, 2013, at 8:36 a.m., in the resident's room revealed the resident in bed with a nasal cannula in place and the oxygen concentrator in operation. Further observation revealed both filters on the oxygen concentrator were white with debris. Interview, on November 20, 2013, at 8:36 a.m., with Registered Nurse #1, in the resident's room, confirmed both oxygen concentrator filters "were dirty." Further interview confirmed they should have been cleaned.	F 441			
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	F 456			

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F 456	<p>Continued From page 9</p> <p>dietary department failed to maintain a pressure steamer in safe operational condition and created a safety hazard for dietary employees.</p> <p>The findings included:</p> <p>Observation on November 20, 2013, at 7:30 a.m., in the dietary department revealed an approximately four inch wide stream of water from the pressure steamer running on the floor to the trayline in operation. Further observation revealed dietary staff walking in and through the area of the water.</p> <p>Interview on November 20, 2013, at 7:30 a.m., with the dietary chef present during the observation, revealed the pressure steamer had "...been leaking a long time..."</p> <p>Interview on November 20, 2013, at 7:45 a.m., with the Certified Dietary Manager, by the pressure steamer, confirmed the steamer was leaking onto the floor and the water was crossing the floor to the trayline area.</p>	F 456	<p>F456</p> <p>It is the policy and procedure of AdamsPlace HCC to ensure that the facility maintains all essential mechanical, electrical and patient care equipment in safe operating condition. Kitchen floor surrounding steam table was mopped and wet floor signs placed around area on 11/19/13. Service company called to evaluate steam table and either repair/replace based on their observation of equipment. Dietary staff in-serviced by Certified Dietary Manager on 12/18/13 on mopping wet area around steam table and keeping wet floor signs in place until steamer repaired/replaced. CDM and/or designee will complete a QA monitor weekly for 3 weeks and as needed to ensure ongoing compliance.</p>	12/31/13	